EXHIBIT 1

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIAN'S/MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301

AMENDED 8-21-2017

011835 STATE FILE NUMBER

TYPE/PRINT IN PERMANENT BLACK INK

Ashley Boerna

NAME OF DECEDENT For use by physician or institution

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last): Drema June Ashley
2. SEX: F
3. DATE OF DEATH (Month, Day, Year): 7/8/2017
4. SOCIAL SECURITY NUMBER: 236-70-2786
5a. AGE-Last Birthday (Years): 74
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): 4/8/1943
7. BIRTHPLACE (City and State or Foreign Country): Vanetta, WV
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No): NO
8a. PLACE OF DEATH (Check only one; see instructions on other side): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 190 Oakland Ave
9c. CITY, TOWN, OR LOCATION OF DEATH: Smithers
9d. COUNTY OF DEATH: Fayette
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name):
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: 901 989 Own Residence
13a. RESIDENCE—STATE: WV
13b. COUNTY: Fayette
13c. CITY, TOWN, OR LOCATION: Smithers
13d. STREET AND NUMBER: 120 Oakland Ave.
13e. INSIDE CITY LIMITS (Yes or No): Yes
13f. ZIP CODE: 25186
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify: NO
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary School (0-12) 16A: 12; College (1–4 or 5+) 16B: 2

PARENTS

17. FATHER'S NAME (First, Middle, Last): Henry Prather
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Gray

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Larry Joe Prather Sr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 68 Gauley Bridge WV 25085

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Bethel Cemetery
20c. LOCATION—City or Town, State: Poe, WV
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Melissa Sanders
22. NAME AND ADDRESS OF FACILITY: Pennington Funeral Home PO Box 699 Gauley Bridge WV 25085
23b. DATE SIGNED (Month, Day, Year):

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-b only when certifying physician is not available at time of death to certify cause of death
23a. To the best of my knowledge, death occurred at the time, date, and place stated.
Signature and Title ▶
24. TIME OF DEATH: Mid P M
25. DATE PRONOUNCED DEAD (Month, Day, Year): 7/8/17
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No): Yes 17-3399

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

CAUSE OF DEATH

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypothyroidism

28a. WAS AN AUTOPSY PERFORMED? (Yes or No): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No): NO

CERTIFIER

29. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
30a. DATE OF INJURY (Month, Day, Year)
30b. TIME OF INJURY
30c. INJURY AT WORK? (Yes or No)
30d. DESCRIBE HOW INJURY OCCURRED
30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

31a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN OR QUALIFIED APRN (Physician or qualified Advanced Practice Registered Nurse certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN OR QUALIFIED APRN (Physician or qualified Advanced Practice Registered Nurse both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER/CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
31b. SIGNATURE AND TITLE OF CERTIFIER: Piotr Kubiczek MD Deputy Chief Medical Examiner
31c. DATE SIGNED (Month, Day, Year): 7/12/17

REGISTRAR

32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Piotr Kubiczek, M.D., 619 Virginia St. W., Charleston, WV 25302
33. REGISTRAR'S SIGNATURE: Ramona J Fox
34. DATE FILED (Month, Day, Year): JUL 18 2017

FORM VS-002 (Rev. 9/2016)

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